

# **New Hampshire Coordinated Strategic Plan for Chronic Disease Prevention and Health Promotion**

**August 26, 2013**



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# **Coordinated Chronic Disease Prevention and Health Promotion**

## **STRATEGIC PLAN**

### **New Hampshire**

#### **I. Executive Summary**

The Coordinated Strategic Plan for Chronic Disease Prevention and Health Promotion (CCDPHP) has been developed with generous contributions of time and thought by representatives of all programs in the Bureau of Population Health and Community Services and their external partner organizations.

During two years of internal meetings, three top priority health goals were selected based on their prevalence in the New Hampshire population and their potential to improve the overall health of the public. These goals are:

- Decrease Tobacco Exposure
- Decrease O b e s i t y , including focus on improving healthy, physical activity, and breastfeeding
- Improve Detection and Management of Chronic Conditions, with emphasis on asthma, cancer, cardiovascular disease, diabetes, and oral health problems

This Plan outlines the burden, risk factors, and associated costs for these challenges to the health of the NH population. It outlines priority objectives developed by Bureau programs under each broad goal, detailed objectives under each health focus area, and recommended strategies to address each objective.

Recommended strategies include those from all four “domains” designated by the Centers for Disease Control (CDC) – Social, Environmental, and Policy Change, Community-Clinical Linkages, Health Systems Change, and Epidemiology & Surveillance. The strategies are listed by domain in each health focus area.

The final section of the Plan describes common priorities, feedback and contributions from community partners to the Plan. Through a series of surveys, interviews and community forums in various geographic areas of the state, partner organizations compared state and local health priorities, analyzing variation in the burden of health conditions across regions. They discussed strategies and activities in each region that could contribute toward achieving the goals and objectives established in the plan.

## **II. Introduction**

For a number of years, categorical chronic disease programs within the New Hampshire Division of Public Health Services (NH DPHS) recognized the need to collaborate to better integrate activities to improve health outcomes for people with chronic conditions. This Integrated Strategic Plan summarizes these efforts, identifies and describes the most important factors affecting the state's burden of chronic disease, and frames a collaborative approach to reducing that burden.

### **An early look at Chronic Disease Integration - 2002**

New Hampshire first addressed the concept of chronic disease integration when the National Association of Chronic Disease Directors (NACDD) offered technical assistance on this topic in the early 2000's. A staff retreat identified goals, activities, and partners common to chronic disease programs. Subsequently a Chronic Disease Section was formed within the Division of Public Health Services. Its staff continued efforts to coordinate and integrate partnerships and communications. However, the scope of early integration efforts was limited by existing infrastructure and continuing requirements of categorical grants. The primary outcome was improved communication among program staff, rather than an integrated approach to chronic disease prevention and health promotion.

### **A Division-wide effort to coordinate internal operations - 2010**

In a separate effort, the NH Division of Public Health Services completed a strategic map in 2010 that identified similar directions for integrating program work internally. The strategic map established integrated work groups for Population Health, Public Health Education and Messaging, Public Health Infrastructure, Resource Allocation, and Organizational Effectiveness. DPHS also produced a State Health Report in 2011 to highlight data from categorical programs; it planned a new system for coordinated data collection across Division programs.

Many objectives in the DPHS Plan – especially those for Population Health -- support integrated planning and activities for chronic disease prevention and health promotion that are similar to the expectations for internal strategic planning outlined in the Coordinated Chronic Disease Prevention and Health Promotion (CCDPHP) funding opportunity. However, until recently the DPHS strategic planning process focused more on adapting internal organizational structure than on integrating goals and objectives to improve population health. NH DPHS has been developing a State Public Health Improvement Plan (SHIP), which includes goals and objectives for health outcomes related not only to Chronic Disease Prevention, but also to other areas such as Infectious Disease and Emergency Preparedness.

### **Coordinated Chronic Disease Prevention and Health Promotion Project – 2011**

In anticipation of the CCDPHP funding opportunity, the Bureau of Population Health and Community Services (“the Bureau”) sponsored a staff retreat in April of 2011. This staff retreat identified priority areas for program integration, including Surveillance, Partnerships, and Communications. Work groups were established for each area; these groups are pursuing Milestones outlined in the Work Plan for the Coordinated Chronic Disease Prevention and Health Promotion grant received in the fall of 2011.

Originally, there was considerable overlap between Division and Bureau objectives for organizational integration. Examples include integrating surveillance systems and communications. Since fall of 2011, staff at both the Division and Bureau levels has been working to develop strategic objectives. The Bureau's focus is on goals common to more than one program, and on objectives that will improve the Division's ability to identify health disparities and focus on populations at risk to improve health risks and outcomes.

### **Integration with the State Health Improvement Plan – 2013**

Chronic Disease Prevention and Health Promotion is one of the most important responsibilities of the NH Division of Public Health Services. As work has progressed on both the CD and State Strategic Plans, it has become obvious that the two documents should be integrated. Thus the Chronic Disease Strategic Plan will be a significant chapter in the SHIP, as well as, a free standing document. The full document will go through clearance and publication as one.

### III. Internal Coordination Planning

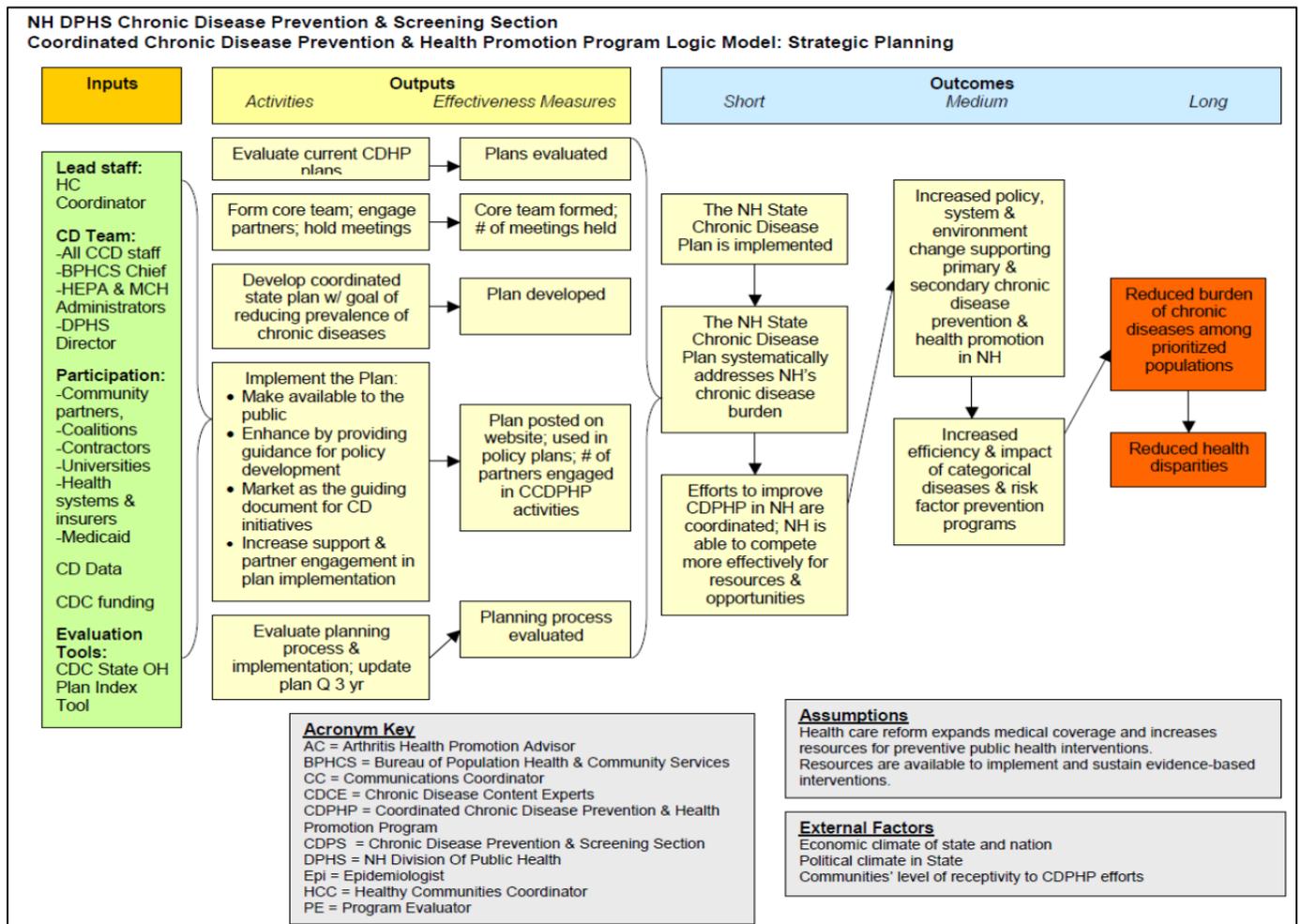
The planning process included all NH DPHS chronic disease and health promotion programs and the other programs which are part of the Population Health and Community Services Bureau, including Asthma Control, Breast and Cervical Cancer, Comprehensive Cancer, Cardiovascular and Stroke Prevention, Diabetes Prevention and Control, Obesity Prevention, Oral Health, and Tobacco Prevention and Control, Maternal and Child Health Section and Women, Infants, and Children (WIC) Program. All of the programs have an essential role to play in promotion of prenatal and life- long healthy behaviors that help prevent the risk and development of many chronic conditions.

#### Integrated Work Groups Established Through the CCDPHP Grant:

Work plans were established for the following groups and included the initial groups identified during the preliminary Strategic Planning Retreat in April 2011, and additional groups that arose from the CCDPHP grant work plan and milestones. The work plan objectives for these groups identified activities to facilitate program integration.

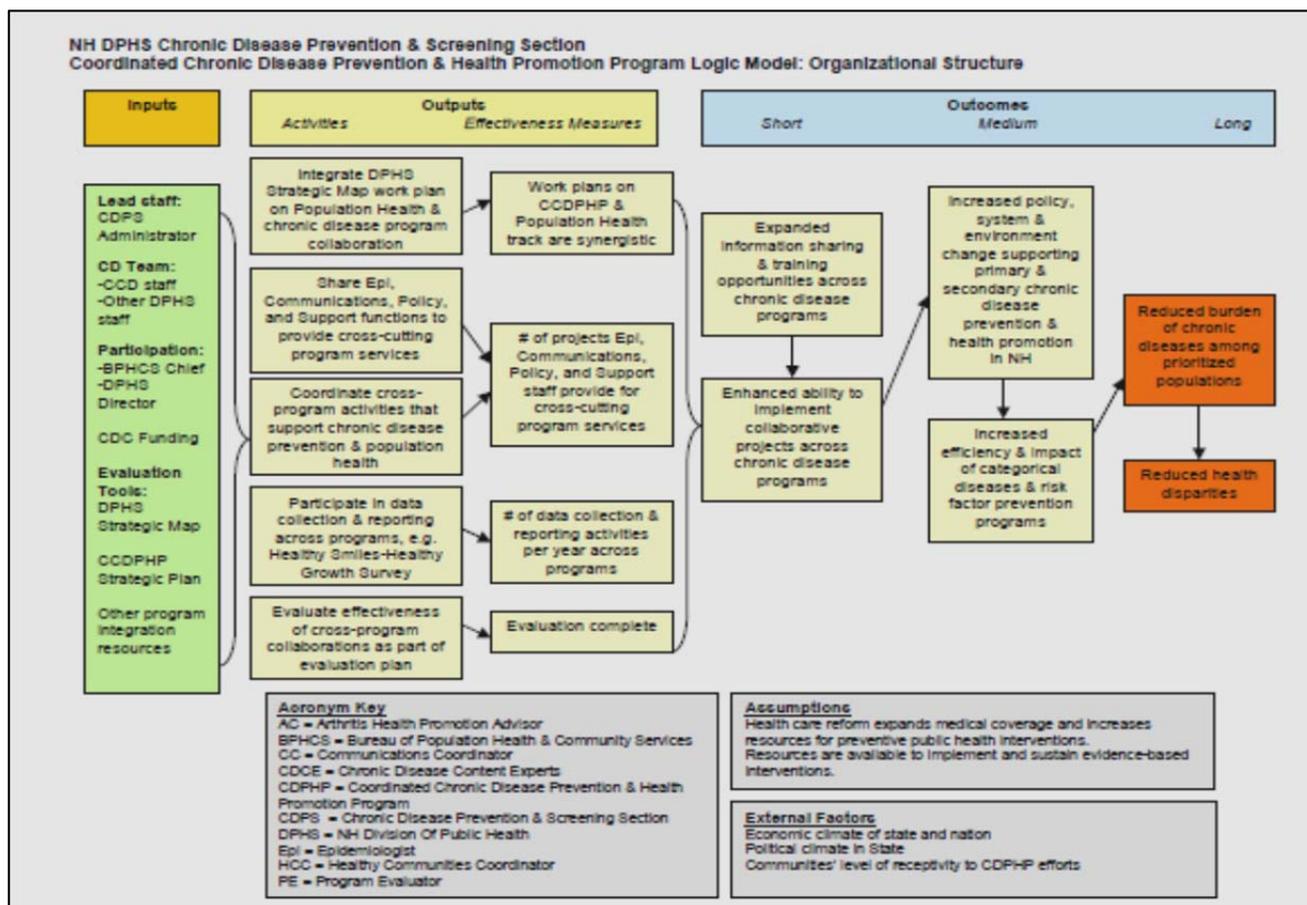
Strategic Plan:

- Develop coordinated chronic disease state plan
- Make the plan available to the public
- Evaluate the plan



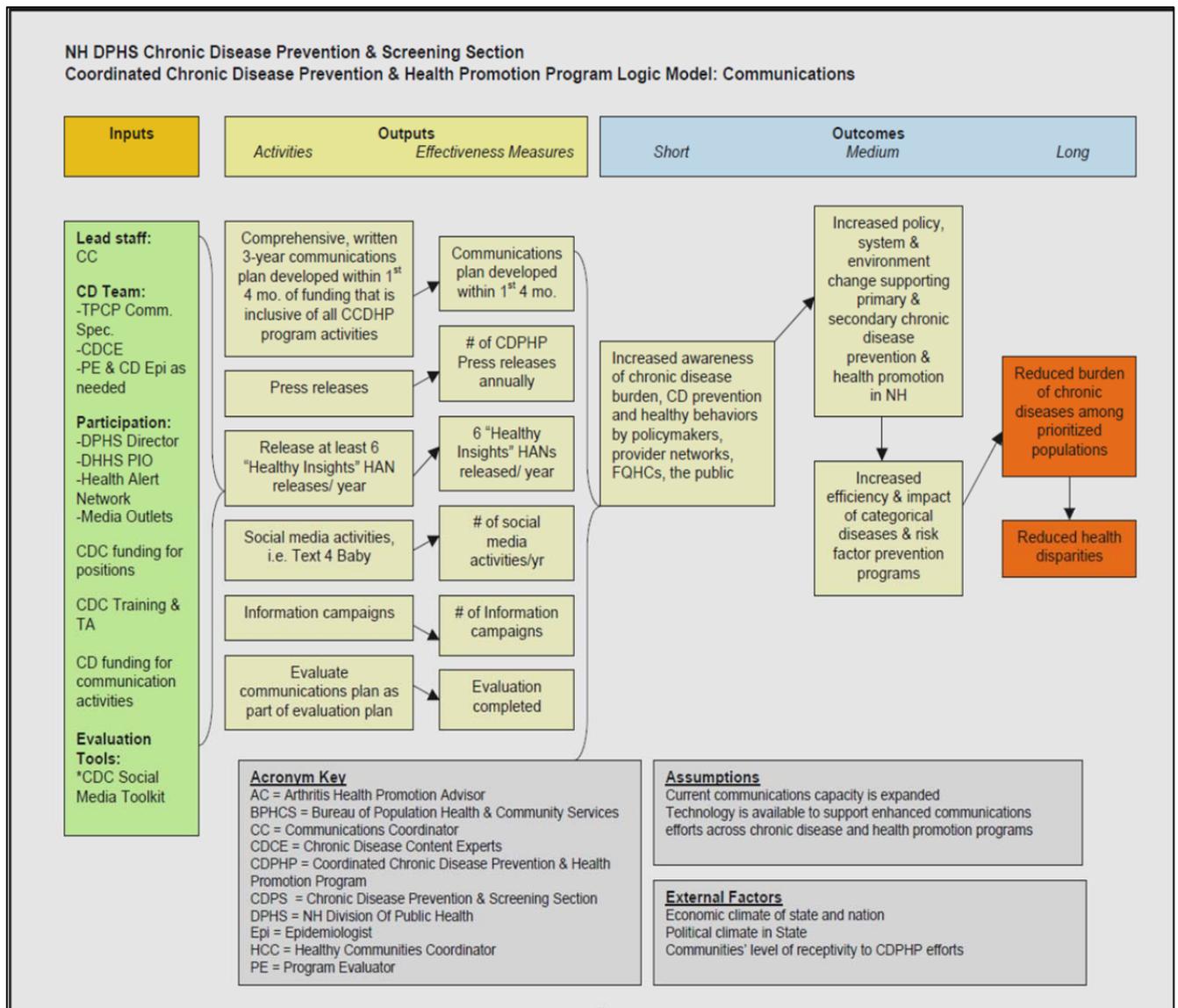
## Organization and Leadership

- Hire, train, and retain chronic disease staff and contractors to oversee the planning, implementation and evaluation of a coordinated CCDPHP program and strategic plan
- Identify strengths and gaps in workforce competencies
- Develop a training plan to address gaps identified
- Maintain a diverse chronic disease work force with the ability to lead strategically and efficiently



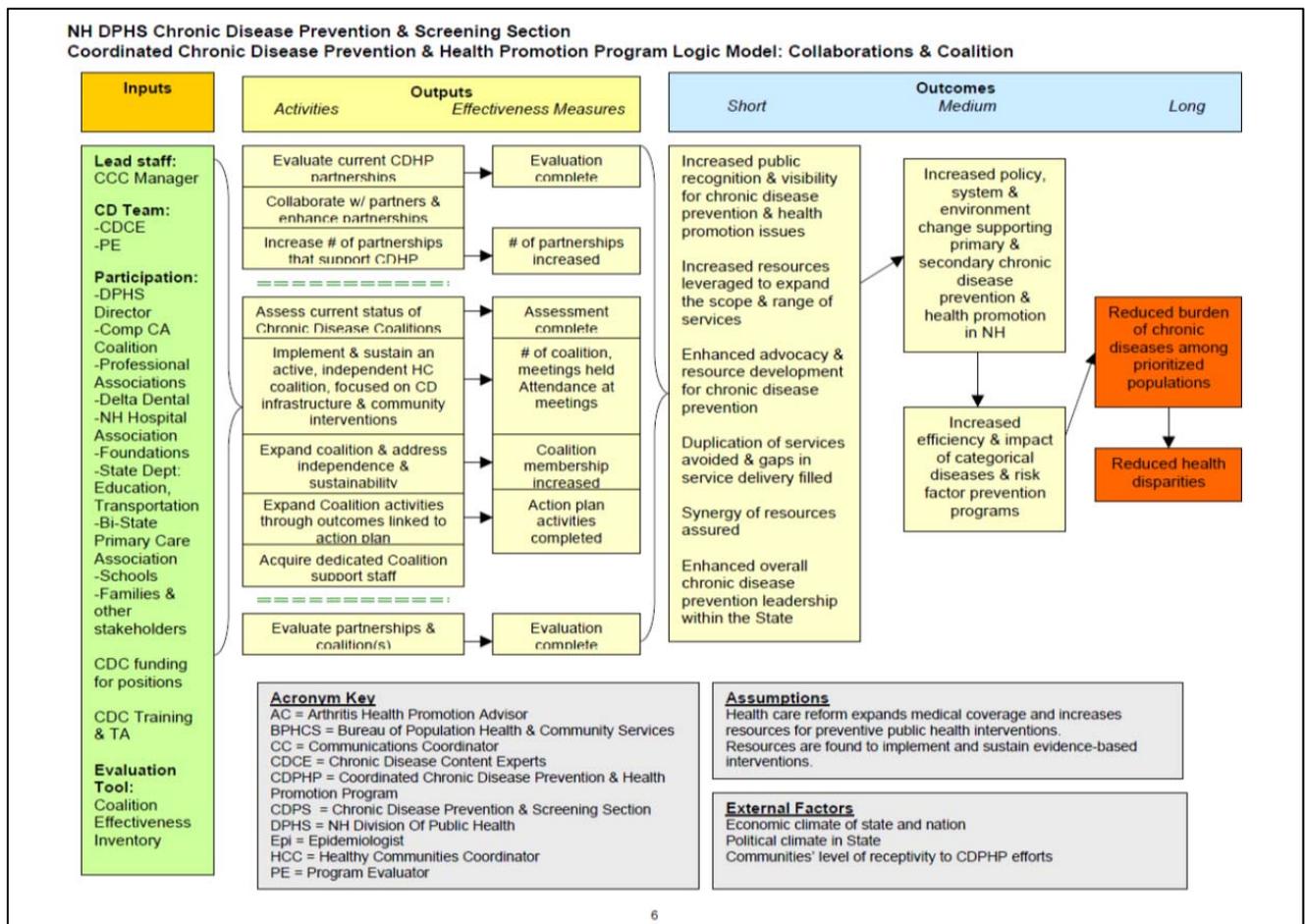
Communications:

- Increase awareness of cross-cutting risk factors for chronic disease in NH
- Publish data to define the burden of top 5 leading causes of death and disability from chronic disease
- Increase awareness of evidence-based strategies for prevention, detection, and management of chronic conditions
- Develop and disseminate key messages about the risk, burden, and strategies for prevention, detection and management of chronic conditions
- Identify key partners to assist the above efforts
- Create an internal plan to respond rapidly to the media and the public



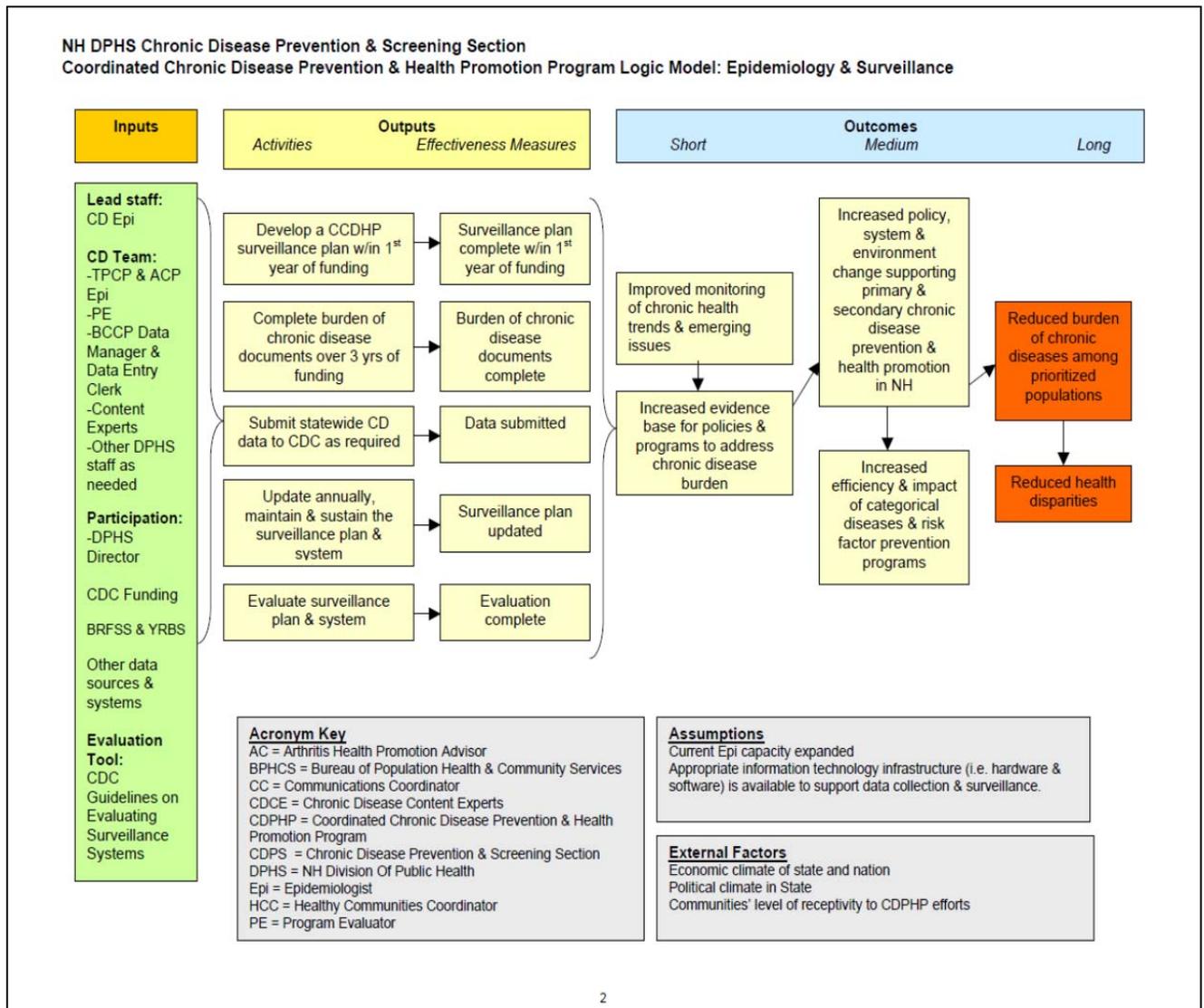
Partnerships:

- Assess existing partnerships and coalitions
- Develop recommendations to enhance partnerships to achieve improved health outcomes
- Establish a functioning cross-program CCDPHP coalition of external partners



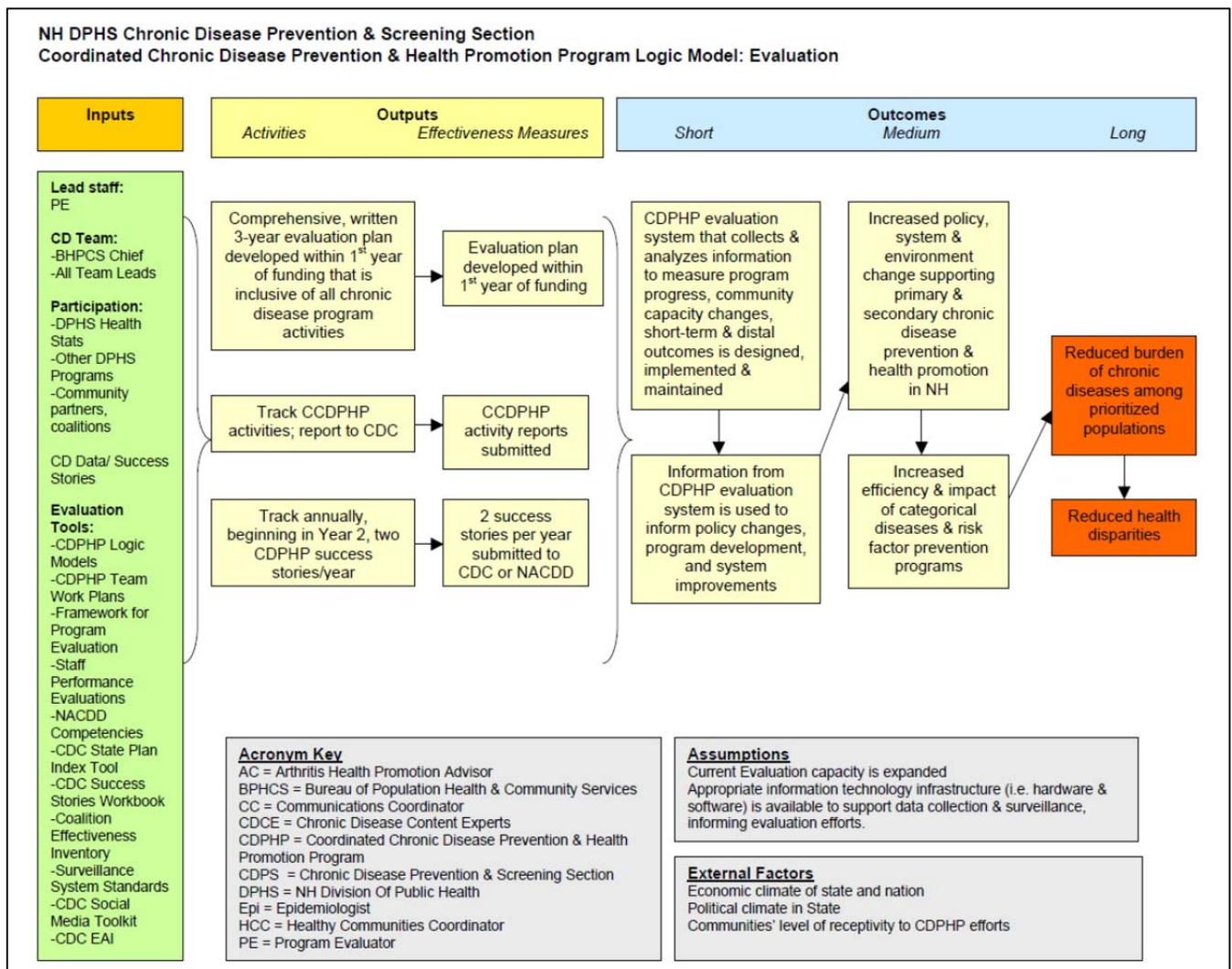
Epidemiology and Surveillance:

- Catalogue existing surveillance reports and data needs related to chronic disease prevention and health promotion
- Identify gaps in surveillance data, and potential sources of needed information
- Develop a coordinated chronic disease surveillance plan
- Assess competencies of epidemiology workforce and gaps in necessary skills
- Develop a plan to address staff training needs



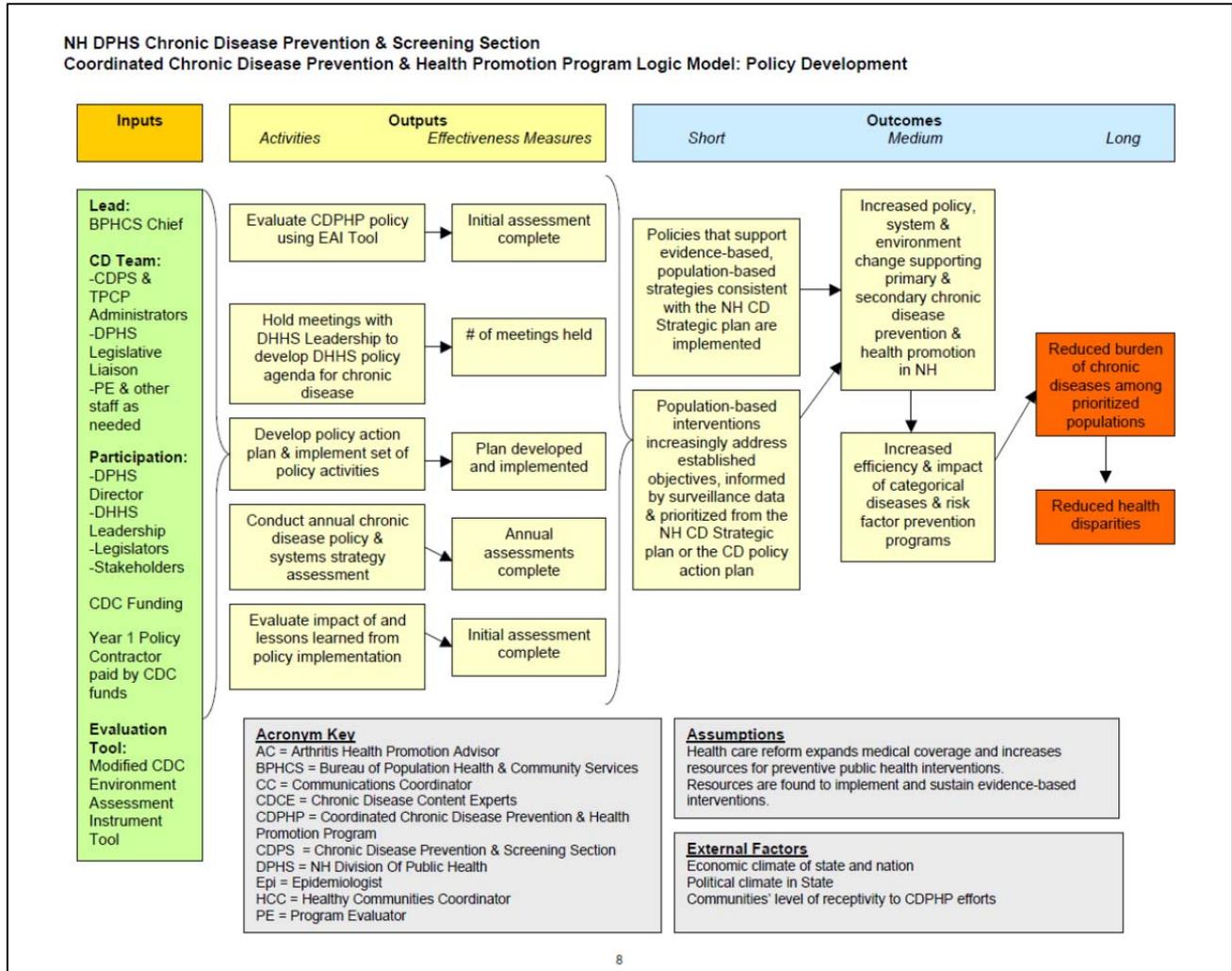
Evaluation:

- Enhance staffing for Evaluation
- Identify existing program evaluation processes and available data to monitor progress toward program and health outcome objectives
- Identify gaps in evaluation process and data
- Develop and update a comprehensive evaluation plan to monitor progress toward program and health outcome objectives



Policy:

- Assess current NH policies affecting health risks and the burden of chronic conditions
- Identify gaps in current policies and developing a policy action plan
- Identify staff training needs related to policy development and developing a training plan



## **IV. PLAN: GOALS, OBJECTIVES and STRATEGIES**

### **Overarching Goals for CCDPHP**

As programs in the Bureau of Population Health and Community Services worked together on the CCDPHP project, it became clear that a focus on several primary health outcome goals could help programs better integrate infrastructure, operations, and communications. Three primary goals aimed at reducing health risks and costs affect and cut across all programs in the Bureau: Reducing Tobacco Exposure; Reducing Obesity; and Improving Detection and Optimal Management of Chronic Disease.

### **Health Focus Areas: Objectives and Strategies**

The body of the Plan (Section III) outlines the primary objectives established by Strategic Planning Work Groups and Bureau Program representatives through the prioritization process for the Division of Public Health Services strategic planning process. This process framed smart objectives, using Healthy People 2020 format when possible and with reference to the Preventive Health Service Guidelines.

## **Goal 1: Reduce Tobacco Exposure**

Reduction in tobacco exposure provides a huge potential to affect health risks, outcomes, and costs. In NH, an estimated 1,700 people die prematurely each year from smoking-related illnesses. An additional 200 die each year from exposure to secondhand smoke. The negative health consequences of cigarette smoking have been well-documented and include cardiovascular disease, multiple cancers, pulmonary disease, adverse reproductive outcomes and exacerbation of other chronic health conditions.<sup>1</sup> Beyond the loss of life, there is a significant economic and social cost. The annual health care cost in NH during 2001-2004 attributable to smoking was \$546 million which translates to an annual state and federal tax burden of \$615 per NH household. During the same period, smoking-caused productivity losses were estimated at \$419 million.

Despite these health risks, an estimated 201,000 NH adults (19.4%) smoke cigarettes<sup>2</sup> Seventeen hundred residents under the age of 18 become daily smokers each year and almost 20% of NH high school students smoke cigarettes. The tobacco industry spends more than \$12.5 billion per year and bombards adolescents with pro-tobacco messages which are reinforced if tobacco use is the norm in their environment. Evidence shows that anti-tobacco media campaigns when combined with other interventions are effective in reducing tobacco use by adolescents.

Cigarette smoking during pregnancy adversely affects the health of both mother and child. Maternal smoking increases the risk for adverse maternal conditions and poor pregnancy outcomes including low birth weight and pre-term delivery. In 2011, 13.6% of NH women of childbearing age (18–44 years) reported smoking.<sup>2</sup> That proportion is higher for women covered by Medicaid (32%) and for teen mothers (26.3%).<sup>2</sup> Both nationally and in NH, smoking prevalence is significantly higher among persons below the federal poverty level and among persons with less than a high school diploma.

Exposure to environmental tobacco smoke (ETS) is associated with many chronic diseases and can lead to adult tobacco use. Tobacco exposure contributes to every chronic disease and associated complications. ETS is especially harmful to children and the elderly and can lead to an increase in respiratory problems and asthma attacks.

Tobacco use is an addictive behavior and requires implementation of multiple, evidence based strategies to promote cessation. More importantly, tobacco use is the single most preventable cause of death and disease.

### **Objectives:**

#### **Adult:**

- Reduce cigarette smoking by NH adults from 19.4% to 12% by 2020

#### **Youth:**

- Reduce the initiation of tobacco use among youths who smoked cigarettes before age 13 from 8.9% in 2011 to 4.2% by 2020
- Reduce tobacco product use by adolescents from 27.9% to 19% by 2015

#### **Pregnant women:**

- Decrease the percentage of pregnant women who report smoking during pregnancy from 13.6% in 2011 to 10% by 2020

## Environmental Tobacco Smoke:

- Support the establishment of laws in States, DC, Territories and Tribes that prohibit smoking in public places and worksites

## Strategies:

### Domain 1: Epidemiology and Surveillance

- Collect and analyze data from the NH Tobacco Helpline to evaluate utilization and effectiveness
- Support the Division of Liquor Enforcement to assist the FDA to assure retailers conform with laws relative to tobacco product labeling, marketing and sales to youth
- Support and expand comprehensive media campaigns to increase tobacco cessation and decrease initiation

### Domain 2: Environmental Approaches

- Provide technical assistance to property management to develop and implement smoke free housing initiatives
- Educate about the effectiveness of cigarette and other tobacco product pricing strategies on reducing initiation and use among adolescents and increasing cessation attempts by adults
- Collaborate with Division of Liquor Enforcement relative to RSA 126K to enforce no tobacco products on school grounds

### Domain 3: Health Systems Change

- Provide technical assistance to NH Community Health Centers to implement Ask, Assist and Refer through QuitWorks-NH
- Ensure access to evidence-based tobacco use cessation services through the NH Tobacco Helpline

### Domain 4: Community-Clinical Linkages

- Assure increased access to tobacco cessation services for populations at greatest risk for tobacco use
- Maintain and expand tobacco prevention and cessation services in public health regions

## Goal 2: Reduce Obesity

Overweight and obesity are associated with increased risk for chronic disease. In NH in 26.2% of adults are obese (BRFSS 2011) and, in 2009, 47.2% of obese adults had ever been told that they have high cholesterol, 42% that they have high blood pressure and 15% that they have diabetes. About 4.6% of obese adults had ever been diagnosed with coronary heart disease, 3.9% with heart attack and 2.1% with stroke. About 25.8% of obese adults had experienced difficulties with daily activities and 33.3% had been told they have arthritis. NH residents with lower educational attainment and lower income suffer disproportionately. Obesity rates vary by county, for example, 69% of adults in the North Country Region are overweight or obese (significantly higher than the State average (62%).

Approximately 18% of New Hampshire's third grade students are obese.<sup>3</sup> Childhood obesity increases the risk for several chronic diseases. Additionally, many nutrition and physical activity habits acquired at a young age predispose individuals to overweight and obesity as adults. Obesity rates are higher in schools with greater than 50% of students participating in the Free and Reduced Lunch Program (27.3%) compared to schools with less than 25% of students participating (16.3%).<sup>3</sup>

Breastfeeding results in improved maternal and infant health outcomes such as reduced risk of hospitalization for lower respiratory tract infections, reduced incidences of otitis media and gastrointestinal tract infections. Breastfeeding is associated with a 36% reduced risk of SIDS. Yet the greatest health consequence of breastfeeding may be related to obesity and chronic disease in later life. Both short and long-term health benefits also accrue to mothers who breastfeed. Cumulative lactation experience correlates with a reduction in hypertension, cardiovascular disease and diabetes, as well as breast and ovarian cancer.

### Objectives:

#### Adult:

- Reduce adult obesity from a baseline of 26.2% in 2011 to 24% by 2015 and 23% by 2020

#### Childhood:

- Reduce childhood obesity from a baseline of 18% in 2008-2009 to 17.2% in 2015 and 16.2% by 2020

#### Breastfeeding:

##### Exclusive at 6 months:

- Increase exclusive breastfeeding at 6 months from 19.6% to 20.7% in 2015 and to 23.7% in 2020

##### Ever breastfeeding:

- Increase ever breastfeeding (initiation) from 82.4% to 83.5% in 2015 and to 85% in 2020

#### At one year:

- Increase breastfeeding at 12 months from 32.3% to 32.3% in 2015 and to 34.1% in 2020

## **Strategies:**

### Domain 1: Epidemiology and Surveillance

- Collect and analyze national, state and program data to evaluate utilization and effectiveness

### Domain 2: Environmental Approaches

- Support implementation of the NH Administrative Rules for Education Regarding Food and Nutrition and the Department of Education's Technical Advisory #21 by continuing to supply toolkits for implementing the rules – identify nutrition standards, communicating policy, maximizing financial gains etc.
- Work with local vendors to improve access to healthy food options in local stores
- Work with school, business and childcare providers to promote policies and activities to increase healthy food options for cafeteria and vending
- Increase capacity of communities to implement policies to improve nutrition by delivering quality technical assistance
- Support healthy routes to school
- Work with schools to promote policies such as increased time for physical education and recess
- Increase capacity of communities to implement policies to improve daily physical activity by delivering quality technical assistance
- Increase capacity of early care settings and schools to implement policies to improve nutrition through technical assistance
- Encourage employee wellness initiatives related to nutrition and physical activity

### Domain 3: Health Systems Change

- Encourage the establishment of “Baby Friendly” Hospitals that promote and support breastfeeding and to assist with staff training and prenatal education to further this strategy

### Domain 4: Community-Clinical Linkages

- Support and promote breast-feeding peer counselors through the WIC program
- Promote and support breastfeeding friendly child care centers
- MCH, WIC and the Obesity Program will work collaboratively to encourage NH Child Care Licensing Regulations to support breastfeeding mothers

### **Goal 3: Improve Detection and Management of Chronic Disease**

Prompt detection of serious chronic conditions, referral to treatment and appropriate management of all chronic diseases is essential to reduce their overall burden and cost to the population. Screening for breast, colorectal, and skin cancers has been shown to reduce morbidity and mortality for those conditions. Screening and prompt treatment for dental caries and other oral health problems prevents chronic pain, tooth loss, and related nutritional deficits. For conditions such as asthma, cardiovascular disease, and diabetes, on-going management according to evidence-based clinical guidelines is the key to preventing complications. Appropriate monitoring and medication, especially for control of blood pressure, cholesterol, and blood sugar, as well as participation in evidence-based self-management programs represent strategies with benefits across multiple chronic conditions.

#### **Focus Area: Cancer**

Breast cancer is the most frequently diagnosed cancer among women in NH and in the US. The National Cancer Institute using 2009 data found that NH had the 9<sup>th</sup> highest rate of breast cancer diagnoses in the country. <sup>4</sup> Despite the fact that early diagnosis and treatment are key to survival, from 2003-2007, 31.5% of NH women diagnosed with invasive breast cancer were diagnosed at late stage.

Cervical cancer used to be the leading cause of cancer death for women in the United States. However, in the past 40 years, the number of cases of cervical cancer and the number of deaths from cervical cancer have decreased significantly. This decline largely is the result of many women getting regular Pap tests. Cervical cancer, like many chronic diseases, disproportionately affects women of low socioeconomic status. Seventy-four percent of women age 18+ with HS or GED had received a Pap test in the past three years compared to 90.4% of college graduates.<sup>5</sup>

Among cancers that affect both men and women, colorectal cancer is the second most commonly diagnosed cancer in NH. Risk factors for colon cancer are age and family history, polyps in the colon or rectum, inflammatory bowel disease, genetic factors and a high fat – low fiber diet. The incidence rate of colorectal cancer from 2005-2009 in NH was 45 per 100,000 people, slightly less than the national rate of 46.2% for the same time period.

Skin cancer is the most common form of cancer in the US and the percentage of people who develop melanoma, the deadliest form, has more than doubled in the past 30 years. The majority of melanomas result from exposure to ultraviolet rays from the sun, tanning beds and sunlamps. The rate of melanoma in NH is significantly higher than the national rate and, in 2009, NH had the ninth highest incidence rate of melanoma in the country.<sup>4</sup> Since 2009, an estimated 350 state residents were diagnosed with melanoma and around 40 individuals died of melanoma<sup>4</sup>

#### **Objectives:**

- Increase the proportion of women between the ages of 40 and 64 who receive a mammogram from baseline 80.4% to 84% by 2020
- Increase the proportion of women who receive a cervical cancer screening based on the most recent guidelines from baseline 74% to 76% of women with a high school diploma or GED
- Increase the proportion of women who receive a cervical cancer screening based on the most recent guidelines from baseline 74% to 76% of women with income below \$25,000 by 2015

- Increase the percent of adults, age 50 and older, who report ever being screened for colorectal cancer from 75.2% in 2010 to 82% by 2020
- Reduce the age-adjusted invasive melanoma incidence rate from a baseline of 28.7% to 26.2% by 2015 and to 21.2% by 2020

## **Strategies:**

### Domain 1: Epidemiology and Surveillance

- Collect and analyze national, state and program data to evaluate utilization and effectiveness

### Domain 2: Environmental Approaches

- Work in recreational and tourism settings to increase sun-protective knowledge, attitudes and intentions and affect behaviors among adults and children
- Work with insurers and worksites to expand interventions to increase screening (e.g., time off for screening related medical procedures, reminder cards and calls)

### Domain 3: Health Systems Change

- Work with providers to utilize electronic medical records to identify those in need of screening
- Expand the use of client reminder systems
- Continue to provide free mammograms through the NH Breast and Cervical Cancer Program to women who live at, or below, 250% of the federal poverty level
- Continue to pay the cost of screening Pap tests through the BCCP for low income, uninsured women
- Provide free screening colonoscopies through the NH Colorectal Cancer Screening Program
- Expand the availability of statewide cancer screening services for all recommended populations
- Work with the Melanoma Foundation of New England to replicate or utilize their provider education component

### Domain 4: Community-Clinical Linkages

- Promote the US Preventive Services Task Force screening recommendations : biennial screening mammography for women aged 50-74
- Raise awareness of the recommended screening intervals for cervical cancer detection – that women 21-65 be screened through Pap tests every 3 years and women 30-65 should also receive an HPV test
- Raise awareness that full body melanoma screening can detect cancer early and make treatment more effective
- Promote community based educational programs: “Your Skin is In” for primary and middle schools and “Teens on Tanning” forums for high school students
- Expand the use of community health workers and patient navigators to ensure the utilization of screening services

## **Focus Area: Oral Health**

Poor oral health is associated with increased risk for diabetes, heart disease and stroke, and adverse pregnancy outcomes. Therapies to treat systemic conditions can compromise oral health. Tooth loss can reduce daily functioning and a person's self-image. In NH, approximately 400,000 adults have had permanent teeth extracted. Left untreated, dental disease progresses, causing periodontal infection, more tooth loss, inability to eat healthy food, time lost from work, compromised systemic health and loss of self-esteem and overall diminished quality of life.

Data from 2010 NH BRFSS demonstrate disparities in oral health by socioeconomic status and showed that 17.5% of NH residents who were 65+ years old were edentulous.<sup>5</sup> Tooth decay is the most common chronic childhood disease. The 2008-2009 NH Third Grade Survey found that 43.6% of participants had caries found by visual open mouth screening.<sup>3</sup> The percentage of people with 1-5 missing teeth increases steadily from the youngest age group (18-24 years) to the seniors group (55-64). Among the group 65+, there is an increasing percentage with all their teeth removed.<sup>5</sup>

### **Objectives:**

- Provide dental screening, referral and restorative services to at least 100 seniors
- Reduce the proportion of third grade students with dental caries in their primary and permanent teeth from a baseline of 43.6% to 41.4% by 2015 and 39.2% by 2020

### **Strategies:**

#### Domain 1: Epidemiology and Surveillance

- Conduct a second Third Grade Survey during the 2013-2014 school year which collects data on oral health and body mass index

#### Domain 2: Environmental Approaches

- Encourage state-wide Community Water Fluoridation

#### Domain 3: Health Systems Change

- Support provision of on-site screening by dental hygienists at WIC clinics and assist necessary referrals and follow-up care

#### Domain 4: Community-Clinical Linkages

- Through a NACDD-funded pilot program with six senior centers, facilitate dental screening by registered dental hygienists and provide referral for restorative services for older adults
- Improve access to dental screening and reparative services for child

## Focus Area: Asthma

The consequences of asthma exacerbation and of uncontrolled asthma include death, disability, reduced quality of life and limitations in daily activities. These result from both asthma and associated comorbidities and related real or perceived limitations. People with asthma have a higher prevalence of obesity, diabetes, COPD and depression.

New Hampshire has one of the highest current asthma prevalence rates in the U.S - 10.4% of NH adults (approximately 110,000 adults) had current asthma in 2010.<sup>3</sup> In 2009, about half (45%) of adults had asthma that was not well controlled.<sup>6</sup> And 8.4% of NH children (0 to 18 years) had current asthma (approximately 25,000 children) in 2008. One third (34%) of these had asthma that was not well controlled.<sup>6</sup> Approximately a dozen NH residents die from asthma each year.

Asthma prevalence in NH is significantly higher among females compared to males (14% versus 6%), individuals with lower income and education levels (16% among those with incomes of less than \$25,000 compared to 9% among higher income adults) and NH adults with Medicaid (approximately 35% compared to 9.5% of adults whose insurance source is an employer).<sup>7</sup>

### Objectives:

- Reduce the rate of ambulatory discharges (ED and Observation stays) due to asthma from 47.9 per 10,000 in 2007 (BRFSS, Asthma Call Back Survey) to 37.2 per 10,000 in 2015 and to 31.2 by 2020
- Increase the proportion of children with current asthma who miss no school days during the year due to asthma from 66.2% in 2006-2008 (BRFSS, ACBS) to 75% in 2015 and to 84% in 2020
- Increase the proportion of adults with current asthma who have well-controlled asthma from 54.7% in 2006 (BRFSS ACBS) to 69% by 2020
- Increase the proportion of children with current asthma who have well-controlled asthma from 66% in 2006 (BRFSS ACBS) to 83% in 2020.

### Strategies:

#### Domain 1: Epidemiology and Surveillance

- By 2020, enhance DOE IAQ checklist automated features, reporting system, and evaluation process

#### Domain 2: Environmental Approaches

- By 2020, all NH Public Health Networks will implement the *Healthy Homes One-Touch+ Approach* to making homes healthier, safe and energy efficient
- By 2020 adopt developed *School Building Environments and Children's Health* teaching module into teacher certification and school professional development programs

#### Domain 3: Health Systems Change

- By 2020 increase by 75% as compared with 2011-2012, the number of providers and primary, acute and/or specialty care sites that complete *Improving Asthma Management Series (IAMS)*

continuing medical education (CME) webinars and schedule certified asthma educator (AE-C) technical assistance

- By 2020, increase the number of practicing NAECB certified asthma educators in New Hampshire by 40% as compared to baseline. Feb 2011: 25 certified asthma educators, 2 in the North Country. Target: 35 practicing certified asthma educators, at least 4 in the North Country
- By 2020, increase by at least two new sites annually the number of primary, acute or specialty care sites that participate in an *Asthma Quality Improvement Project (AQIP)* and demonstrate progress on at least two practice improvements to deliver asthma services according to NAEPP EPR 3 Asthma Guidelines

#### Domain 4: Community-Clinical Linkages

- By 2020, increase by 30 percentage points from 2012, the proportion of elementary and middle school students who have persistent asthma who also have a current asthma action plan in school

#### Focus Area: Diabetes

Diabetes is the seventh leading cause of death in New Hampshire.<sup>2</sup> Diabetes is also a leading cause of blindness, kidney failure, and lower limb amputation.<sup>8</sup> Persons with diabetes should receive a number of clinical preventive services as many complications of diabetes can be prevented through proper care. NH ranks 37<sup>th</sup> in the country in diabetes prevalence. In New Hampshire, diabetes-related hospitalizations increased from 138 in 2000 to 145 in 2007 (age-adjusted, per 10,000 population). Diabetes emergency room admissions for ambulatory sensitive conditions increased from 10.7 in 2000 to 13.5 in 2007 (age-adjusted, per 10,000 population). These are expected to increase along with the prevalence of diabetes.

According to BRFSS 2011, the prevalence of diabetes was 8% among NH adults and another 6.6 % of NH adults reported ever being diagnosed with prediabetes. Prediabetes is often undiagnosed. Up to 35% of NH adults could have prediabetes based on national estimates from the National Health and Nutrition Examination Survey.<sup>9</sup>

Adults with diabetes have heart disease and stroke death rates about 2 to 4 times higher than adults without diabetes. It is estimated that 65% of deaths among people with diabetes are due to heart disease or stroke. In 2010, 15.3% of adults with diabetes in New Hampshire reported having coronary heart disease, 15.5% reported having had a heart attack, and 6.9% stroke. Further increasing their risk for coronary heart disease, 16.5% reported cigarette smoking.<sup>2</sup>

#### Objectives:

- Maintain diabetes-related emergency department admissions for ambulatory sensitive conditions below 15 per 10,000 population (baseline 13.5 per 10,000 in 2007)
- Maintain diabetes-related hospitalizations below 150 per 10,000 population (baseline 141.1 per 10,000 population in 2007)

#### Strategies:

##### Domain 1: Epidemiology and Surveillance

- Collect and analyze national, state and program data to evaluate utilization and effectiveness

## Domain 2: Environmental Approaches

- Increase capacity of communities to implement policies to improve nutrition by delivering quality technical assistance

## Domain 3: Health Systems Change

- Encourage adherence to evidence-based professional guidelines for clinical management
- Increase awareness of prediabetes and its consequences among healthcare providers and the public
- Identify organizations that have the capacity to deliver the National Diabetes Prevention Program

## Domain 4: Community-Clinical Linkages

- Provide technical assistance and professional education opportunities for clinical staff to promote best practices in diabetes management with a focus on the ABCS of diabetes (hemoglobin A1c, blood pressure, cholesterol and smoking) among patients at NHDEP clinical sites
- Screen those with identified risk factors for pre-diabetes and diabetes
- Collaborate with partners to enhance community-clinical linkages to increase referrals to evidence-based programs for those at risk for type-2 diabetes
- Referral to resources for physical activity and healthy eating

## **Focus: Cardiovascular Disease and Stroke**

Coronary heart disease is the most common type of heart disease that can lead to a heart attack. In NH, heart disease was the second leading cause of death in 2008 (1700 deaths) and 5583 people were hospitalized due to heart disease.<sup>10</sup> NH is ranked 29<sup>th</sup> in the country for coronary heart disease. In 2008, stroke was the fourth leading cause of death in the US and in NH.<sup>11</sup> In NH in 2008, 484 deaths occurred and 1670 people were hospitalized due to stroke.<sup>11 12</sup> Four hundred eighty-four deaths occurred and 1670 people were hospitalized due to stroke in NH in 2008.<sup>12</sup>

Modifiable risk factors for both heart disease and stroke include high blood pressure, high blood cholesterol, diabetes, overweight and obesity, tobacco use, alcohol use, physical inactivity and unhealthy diet. In 2009, nearly 29% of NH residents reported having high blood pressure and about 25% of them did not take their prescribed medications.<sup>13</sup> New Hampshire is ranked 24<sup>th</sup> in the country for high blood pressure and trending higher. Over 38% of NH residents were estimated to have high blood cholesterol, which was second highest among the New England states.<sup>14</sup> New Hampshire is ranked 29<sup>th</sup> in the US for high blood cholesterol.

## **Objectives:**

- Reduce coronary heart disease deaths from 116 deaths per 100,000 population to 110 by 2020
- Reduce hospitalizations for stroke from 11.6 per 10,000 population to 8 per 10,000 population by 2020
- Reduce stroke deaths from 33.2 deaths per 100,000 population to 28 deaths per 100,000 population by 2020

- Reduce the proportion of adults with high blood pressure from 28.6% to 26% in 2015 and to 22% in 2020
- Reduce the proportion of adults with high blood cholesterol from 39% to 30% by 2020

**Strategies:**

Domain 1: Epidemiology and Surveillance

- Collect and analyze national, state and program data to evaluate utilization and effectiveness

Domain 2: Environmental Approaches

- Reduce sodium in the food supply through policy change and collaboration with food manufacturers and vendors
- Collaborate with food services at worksites to identify and make available selections low in saturated fat and calories with expanded access to fruits, vegetables and grain products
- Disseminate public messages regarding early warning signs of heart attack and stroke, risks of high blood pressure, guidelines and recommended strategies for blood pressure control
- Support farmers' markets and community gardens
- Promote policy change to support physical education programs within school curricula and community activity centers

Domain 3: Health Systems Change

- Distribute evidence-based blood pressure tool kit to providers

Domain 4: Community-Clinical Linkages

- Assist community-based programs to improve nutrition, physical activity and smoking cessation
- Collaborate with park and recreation officials to promote facilities for local outdoor recreation
- Assure access to cholesterol screening, counseling and referral services

#### IV. Conclusion

The result of planning for Coordinated Chronic Disease Prevention and Health Promotion is a tribute to dedicated Population Health and Community Services staff that contributed invaluable information and expertise in addition to regular programmatic duties. Many of the original plan outcomes were predicated on adding 3 positions dedicated to CCDPHP. With CDC unable to provide years 2 and 3 funding; only a part-time coordinator was put in place. Funds were eventually found to provide a full-time contract for the epidemiology/surveillance position.

Those contributions are all the more significant in light of multiple initiatives moving forward at the same time that coincide with staff and budget cuts. External partners contributed insight and perspective throughout the process as a result of input sessions conducted in every corner of the state and an exhaustive survey.

As described in the introduction, year-long processes have been completed by both the Division and the CDPHP to: 1) collect and analyze health data, 2) identify broad health goals, 3) develop specific objectives, and 4) prioritize among those objectives based on a set of defined criteria.

New Hampshire's most important health goals and objectives rest on a thorough analysis of the burden and cost of chronic conditions and the anticipated benefits of achieving the objectives outlined in this report.

In contrast to the Bureau's internal strategic plan, the external plan focuses on integrated objectives to improve population health outcomes and includes statewide partner input. Objectives related to a sustainable plan development include:

- Identify health risk factors that affect the burden of chronic disease in New Hampshire
- Identify populations most at risk for chronic conditions and poor health outcomes
- Schedule a strategic release of data including actionable steps that can be taken by stakeholders to sustain efforts to improve public health
- Develop common priorities across programs to decrease disease risk and improve health outcomes
- Catalogue current program objectives and categorize these according to the four Chronic Disease Prevention Domains
- Prioritize objectives within each health focus area
- Convene partners to contribute to and refine Strategic Plan
- Identify evidence-based strategies to address those objectives
- Develop more consistent outcome measures for each priority objective
- Establish a process to evaluate interventions, strategies, and progress toward Strategic Planning goals

The NACDD professional competency assessment was done in 2012 and training needs were identified and prioritized. The analysis resulted in an exhaustive list of training topics many of which were addressed by staff with appropriate skills and experience. Some training takes place at the monthly all staff meeting along with standing business items and will continue through March 2014 and beyond.

A Learning Collaborative has been established, meets monthly and is dedicated to training topics identified by staff during the assessment as well as opportunities that have arisen since e.g. through webinars put on by professional organizations, through the NACDD Learning Center. The CDC's *Enhancing Coordination Update* is a wealth of learning opportunities that is shared with all Bureau staff on a weekly basis.

Journal Club meets monthly to read, analyze and discuss published primary research that addresses chronic disease issues. Individual training plans are, and will continue to be, established between individual staff members and their supervisors. The CCDPHP Coordinator will continue to oversee these activities until March 2014 and, by that time, continued staff development activities will be embedded in the Bureau's routine. Topics that have been addressed, to date, are listed in Appendix IV.

A comprehensive chronic disease Communication Plan was submitted in the fall of 2012. Tasks were outlined in a work plan and timeline and have been assigned to various members of the Communication Work Group. Specifics for grant year three include, but are not limited to:

- Update program talking programs
- Continue to connect surveillance data to key messages and public health stories
- Evaluate and report on the Communication Plan
- Success stories regarding chronic disease integration will be written and submitted as requested through March 2014

The CCDPHP Coordinator will continue to be a member of the Communication Work Group. By March of 2014, a Work Group chair(s) will be identified to ensure sustainability of the Communication Plan and coordination with Division communication activities. Strategic releases of data will be a combined effort of the Surveillance Work Group and the Communication Work Group.

The CCD contractor, Community Health Institute, completed, analyzed and made recommendations from a Social Network Analysis which identified strong external partner relationships as well as gaps in crucial areas. The Executive Summary and list of recommendations can be found in Appendix II. The CCD Collaboration (Partnership) Work Group was instrumental in completing a Partnership Analysis which was the basis for the larger effort. The Work Group will be reconvened and charged with publicizing the plan and implementing the recommendations.

The stakeholder Summit, entitled Alliance of Healthy Community Coalitions was held in May 2013. As a result of the work begun at that all-day meeting and the roadmap provided by the Social Network Analysis, a state-wide coalition will continue to emerge.

The CD epidemiologist and the Surveillance Work Group have completed an assessment of data needs and software needs and have identified gaps that need to be addressed by Division management. The reports have been submitted and the CCDPHP coordinator will work closely with the CD epidemiologist and the work group to move the recommendations forward.

The CD epidemiologist and work group have made the following recommendations:

- Select and adhere to CDC's common indicators whenever possible
- Coordinate release of publicly available reports, constitute common distribution lists, standardize reports (common graphics, common content structure), develop templates
- Utilize WISDOM for standard reporting (WFRS, PNSS, PedNSS) and as a base for other periodic (non-varying) reporting
- Prepare coordinated plan to secure resources to support underfunded and understaffed data collection and analyses
- Prepare coordinated plan for hardware and software update; in particular secure funding and sustained availability of SAS, update and match of Microsoft Office suite

Because funds were not available for years 2 and 3 of the grant, a CD evaluator was not hired. Consequently, the CD epidemiologist has been doing program evaluation according to a schedule laid out in the March 2013 CD Evaluation Plan. The CD Strategic Plan and the Communication Plan have been evaluated. The CD epidemiologist and the Surveillance Work Group will oversee this task.

The NH Chronic Disease Strategic Plan draft was assessed using the CDC State Plan Index.<sup>15</sup> All Bureau staff who has been involved in CD integration was included in the process. The results were encouraging in some areas but much work remains. The CD Strategic Plan Work Group will continue to adopt the recommendations to improve this plan over time and to integrate it into the State Health Improvement Plan.

The Division held a number of local “listening events” to gain input from external partners about how to conduct our work in the future. This exercise culminated in a state-wide Summit in late May attended by high-level stakeholders. The results as they relate to Chronic Disease are found in the Summary Report of Community Meeting Input in Appendix I.

The revision of the Plan strengthens the connection of program goals and objectives to the 4 domains. At the same time, the Division is creating a State Health Improvement Plan (SHIP). The Chronic Disease plan will be released both as a document in its own right but also as a major and critical component of the SHIP. Documentation of publication will be provided by March 2014. The CCDPHP Coordinator will continue to oversee these activities until March 2014 in conjunction with the Chief of the Bureau of Public Health Systems Policy and Performance who is responsible for the SHIP. It will be through the SHIP that sustainability will occur.

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## Appendices

**Appendix I**  
Executive Summary of Community Input Report

**Coordinated Chronic Disease Prevention**  
Summary Report of Community Meeting Input  
**2012–2013**

Summary

The Division of Public Health Services, Coordinated Chronic Disease Prevention and Health Promotion contracted with the Community Health Institute (CHI) to administer enhanced services for the development, implementation and evaluation of a coordinated chronic disease strategic plan, including providing services to enhance partnerships for a healthy community’s coalition. One component of this work was to develop and implement a process to gather public and partner input into the draft coordinated chronic disease prevention and health promotion strategic plan.

The CHI/State Coordinated Chronic Conditions team conducted six Community Meetings in each of five separate regions of the state and then a statewide meeting aimed at organizations serving populations across the lifespan. The purpose of the meetings was to gather feedback on the key state priorities (Appendix A) identified for addressing public health and chronic diseases and their impact to the health of New Hampshire’s citizens. This feedback and buy-in by community partners will help to mobilize community action on these public health priorities, a critical component for New Hampshire to succeed in addressing public health issues. Using an audience response system, participants in all of the community input sessions voted on the importance of the priorities. The ranking by priority is listed in the following table, along with the aggregate voting results. Individual session results are included in later sections of this report. There is a section for each community input session that can serve as a freestanding report for each community.

Overall Rankings by Order of Importance

- 1. Obesity and Diabetes Prevention 15.2%**
- 2. Heart Disease and Stroke Prevention 11.7%**
- 3. Tobacco Prevention 11.1%**
- 4. Healthy Mothers and Babies 10.8%**
- 5. Cancer Prevention 10.7%**
- 6. Misuse of Alcohol and Drugs Prevention 10.3%**
- 7. Infectious Disease Prevention 8.5%**
- 8. Injury Prevention 8.0%**
- 9. Emergency Preparedness 7.1%**
- 10. Asthma Prevention 6.7%**

Detailed results of the survey used in each community input session are included in full in Appendix B.

**PREVENTION ACTIVITIES CURRENTLY IN PLACE**

Prevention activities identified by participants during community input sessions that are currently in place are organized by the National Prevention Strategy framework across health priorities in Appendix C. Cross-cutting National Prevention Strategies currently in place that address at least six of the ten priority areas are listed below:

- Providing people with tools and information to make healthy choices.
- Engaging and empowering people and communities to plan and implement prevention policies and programs.
- Ensuring a strategic focus on communities at greatest risk.
- Supporting implementation of community--based preventive services and enhancing linkages with clinical care.
- Enhancing cross-sectoral collaboration in community planning and design to promote health and safety.

- Maintaining a skilled, cross-trained, and diverse prevention workforce.
- Standardizing and collecting data to better identify and address disparities.

## **RECOMMENDATIONS**

Community members were asked at each input session how the State could support their prevention efforts. Detailed recommendations are outlined in the report in two ways: 1) aggregated by health priority, and 2) by region. Recommendations centered on strategies that addressed promoting healthy and safe community environments, improving clinical and community preventive services, empowering people, and eliminating health disparities. Details outlining recommendations organized by the National Prevention Strategy framework by specific health priority can be found in Appendix D. Cross-cutting National Prevention Strategies that address at least six of the ten priority areas are listed below:

- Enhance coordination and integration of clinical, behavioral and complementary health strategies.
- Ensure a strategic focus on communities at risk.
- Provide people with the tools and information they need to make healthy choices.
- Engage and empower people and communities to plan and implement prevention policies and programs.
- Enhance cross-sectoral collaboration in community planning and design to promote health and safety.
- Maintain a skilled, cross-trained, and diverse prevention workforce.

- **CONCLUSIONS**

The NH tradition of partnerships is evident in the prevention activities in place that focus on individual and community engagement and cross-sectoral collaboration, and its focus on at-risk populations. The State can support regional efforts by supporting these activities, as well as enhancing workforce development, supporting prevention education, and fostering coordination and integration of clinical, behavioral and complementary health strategies. In addition to comparing activities and recommendations across regions, this report positions the State and participating regions to apply a systematic strategy for implementing effective, evidence-based strategies to address identified gaps.

## **Appendix II**

### Executive Summary of Social Network Analysis

#### **New Hampshire Chronic Disease Prevention Network: PARTNER Analysis**

In our current environment of constrained resources, funders and providers recognize the increasing value of a coordinated approach to chronic disease prevention and control and risk factor reduction. Potential funding opportunities increasingly require evidence of partnerships at state, regional and/or local levels. The CDC funded the New Hampshire (NH) Division of Public Health Services (DPHS), Bureau of Population Health and Community Services (BPHCS) to develop a more coordinated approach to chronic disease prevention. The DPHS/BPHCS identified tobacco exposure, obesity, and chronic disease as health priority areas, and identified an aim to better coordinate the work of chronic disease programs and health Promotion Programs.

The purpose of this project was to better understand existing partnerships among NH organizations working on these health priority areas in order to inform a coordinated approach to chronic disease prevention. Social network analysis is an emerging method for understanding the context within which local public health networks function, and as such, provides a systems approach that not only examines various parts of the system, but more importantly, the inter-relationships between the parts. On behalf of the BPHCS, the Community Health Institute/JSI administered a 42-item web-based survey to a list of 278 partners from regional, multiregional, state level and state governmental organizations that yielded a 64% response rate.

Survey data describe connections and collaboration among organizations that provide prevention services targeting tobacco exposure, obesity, and chronic disease within each region and across the state. The findings include descriptions of the types of services provided in what settings to which populations across the three health priority areas, as well as quantitative measures about collaboration between networks of partners at various system levels:

Statewide, state level organizations only, State Government, BPHCS, and each of the 14 public health regions. Specific network measures are reported, as well as centrality, relative connectivity, trust and value to the network for each organization. The findings provide a basis for identifying gaps, developing comprehensive strategies, and cultivating synergies to enhance productive relationships. Participating organizations provided suggestions for improving coordination within their regions across the health priority areas, and identified potential partners to include in this work.

Based on the findings, the following recommendations are offered:

- Review the list of partners to insure that all partners are represented
- Acknowledge members on the current list, communicate recognition for responding to the survey, and share findings from the survey with them.
- Review response rates by sector, and consider outreach/education to sectors with lower rates (Education, Statewide Coalitions, Social Services, and Private Organizations).
- Identify “isolates”, which are those organizations without links to other partners. These organizations did not respond to the survey, and no responding organizations identified them as partners.
- Consider reaching out to those who were identified by participating partners as “missing from the list”
- Use the findings to inform any strategic relationship management planning.
- Recognize partners with high connectivity, trust and value scores, and ensure that they are actively engaged in any planning and implementation strategies for improving coordinated approached to chronic disease prevention.
- Work with highly connected members to identify ways to engage partners with high trust and /or value scores and strategize about how to either 1) improve their connectivity with the existing network, or 2) maximize potential to expand the network in size and/or diversity by maximizing the value of these organizations as entrees to new networks.

- Explore “Most Important Contributions” to ensure that the network is maximizing existing resources, and to identify gaps.
- Make and/or take advantage of opportunities to share across sectors and system levels the roles and goals of various partners. Trust scores can be improved by increasing understanding about why organizations are – or should be – engaged in collaborative efforts.
- Provide incentives for organizations engaged in more than one health priority area that can offset costs for managing collaborative activities/initiatives/efforts.
- Celebrate individual organizations’ and network achievements
- Carry forward this systems approach to apply a strategic approach to collaborative management.

Establishing and maintaining relationships across organizations requires an investment of time and other resources. Application of a strategic approach to resource allocation for partnership development may represent an opportunity to improve the delivery of prevention services in NH. Findings from this assessment will facilitate informed public and partner input into coordinated chronic disease prevention and health promotion strategic planning, inform a contextually relevant policy action plan, and enable measurement of changes in collaborative processes and outcomes over time. This measurement capacity is essential to the DPHS performance management framework, and it incorporates a cross section of public health essential services that are integral to public health accreditation.

### Appendix III

#### Competencies Matrix – Staff Development Plan

TRAINING PLAN PRIORITIES								
NACDD Domain	Training Topic	One Session or Series	CD Group or Individual	Internal and/or External Resources	Coordinator	Level of Importance- 1- priority 2- neutral 3- not a priority	Questions/ Clarification	Disposition
<b>Build Support</b>								
	Grant Writing			ASTPHND/Lissa Siros		1=3 2=7 3=0	Federal grants/Foundation grants	12/26 - e-mailed question to LS.
	Medicaid - Care Mgt Prevention Svcs	1. NH Medicaid org. 2. How to best communicate with recipients 3. Scope of service 4. Chosen contractors 5. ROI	Meeting scheduled with one contractor - Meridian.	DHHS Information Sessions 10/15+22/12		on hold until after Medicaid presentations		Does anyone still want to invite someone from Medicaid to attend this meeting and explain (i.e. I saw a presentation by Dr. Lotz at the CCC Board meeting)
	Advocacy v Lobbying.				Kate Frey T/Drive/OCPh1/ Legislative/IVLobbying Related Policies	1=0 2=0 3=all		Anything more needed? Invite kate to meeting? She did present at a staff mtg.

<b>Design and Evaluate Programs</b>								
	Data Availability				Lida? Report on the S: drive WISDOM?	1=8 2=3 3=0	drive for reading Learning Collaborative	e-mail to Lida 12/26
	Program Evaluation	Overview			David L./UNH Trish Tilley Asthma MCH CCC tool	1=8 2=2 3=0	Learning Collaborative	Done
	Health Economics/ ROI					1=7 2=2 3=1	How in depth? Can this be discussed in the Learning Collaborative?	
	Competency with Different Audiences					1=0 2=6 3=3		
	Cultural Sensitivity					1=3 2=5 3=3		
<b>Influence Policies and Systems</b>								
	Organizational Systems			Shelley Bischoff?		1=5 2=5 3=0		CHI contract
	Feedback loops and	Influencing systems				1=0 2=0 3=all		CHI contract

	Influencing Policy (legislative vs organizational)	Skills and Frustrations		Karla Armenti		1=5 2=6 3=0	Current? Internal? External? Developing?	CHI contract
	Working with PIO			Kris Nielson? Or Nicola Whitely		1=6 2=4 3=1		Done
<b>Lead Strategically</b>								
	Commissioner Weekly Updates						Discussion not training	Learning Collab?
	Integrated data briefs			S drive			Discussion not training	"
	Annual Report				S		Discussion not training	"
	"Leading up"						Discussion not training	"
<b>Manage People</b>								
	Develop the next generation of PH staff					1=8 2=0 3=0		

	Internships	1. Market for internships 2. CSTE/EIS/ PSP 3. Shovel Ready Projects 4. Plymouth/ Keene					Discussion not training	
	CDPHP cross training					1=7 2=2 3=0		
	External Learning			Health Depts, DHMC, other		1=0 2=6 3=3		
<b>Manage Programs and Resources</b>								
	Risk/benefits of Bona Fide agents					1=8 2=0 3=0		
	Budgets	1. Process 2. State/Fed'l 3. Lawson			Margaret Murphy	1=7 2=0 3=0		
	Terminology/ lingo						grant writing	
	Cooperative Agreements				NACDD	1=7 2=2 3=0	grant management	
	Total QI Projects				Laura	1=1 2=5 3=3		

Program Evaluation								
Data Availability	Overview			David L./UNH Trish Tilley Asthma MCH CCC tool	1=8 2=2 3=0	Learning Collaborative	Learning collab - sched day/time. Who organize?	
Develop the next generation of PH staff				Lida? Report on the S: drive WISDOM?	1=8 2=3 3=0	Available on S: drive for reading Learning Collaborative	Lida - do a presentation? 30 min. Feb/ or March mtg.	
Risk/benefits of Bona Fide agents					1=8 2=0 3=0		Internships - learning collab. - Kate?	
Health Economics/ ROI					1=8 2=0 3=0		???	
Navigating Cooperative Agreements					1=7 2=2 3=1	How in depth? Can this be discussed in the Learning Collaborative?	CHI and/or Learning Collab	
CDPHP cross training				NACDD	1=7 2=2 3=0	grant management	CHI - NACDD, sent question 12/26	
Budgets					1=7 2=2 3=0		Learning collab.	
Working with PIO	1.Process 2.State/Fed'l 3.Lawson			Margaret Murphy	1=7 2=0 3=0		Dev budgets? State vs. Fed?	
Organizational Systems			Kris Nielson? Or Nicola Whiteley		1=6 2=4 3=1		Done	

Feedback loops and environmental change			Shelley Bischoff?		1=5 2=5 3=0		CHI	
Advocacy v Lobbying.	Influencing systems				1=0 2=0 3=all		CHI	
Grant Writing				Kate Frey T/Drive/OCPH1/L egislative/IVLobb ying Related Policies	1=0 2=0 3=all		Need addit?	
Influencing Policy (legislative vs organizational)			ASTPHND/Lissa Sirois		1=3 2=7 3=0	Federal grants/Foundation grants	E-mailed Lissa - 12/16	
Medicaid - Care Mgt - Prevention Svcs	Skills and Frustrations		Karla Armenti		1=5 2=6 3=0	Current? Internal? External? Developing?		

## **Appendix IV**

### **Internal Learning Collaborative**

First Tuesday of the Month, 9:00 – 10:00 am. Preceding CCD Staff Meeting

#### **Past Topics:**

Feb 5 – Data availability (Domain 4) – Lida Anderson, CD Epidemiologist

March 5 – Cancelled

April 2 – Back to the Future: From 2011 Retreat to 2013 FOA – Regina Flynn, Obesity Prevention Program Manager/Judy Nicholson, Coordinated Chronic Disease Coordinator

May 7 – Program evaluation – David Laflamme, MCH Epidemiologist

June 4 – Budget Basics – Margaret Murphy, Healthy Eating & Physical Activity Section Administrator

July 9 – Three hour assessment of CD Strategic Plan – Lida Anderson

August 6 – CD Self-Management – Tracey Tarr, Bureau of Elderly & Adult Services

Paula Smith, Southern NH Area Health Education Consortium

September 3 – Evaluating Community Coalitions and Partnerships – Susan Knight, Asthma Epidemiologist

#### **Future Training/Learning Topics**

Navigating Cooperative Agreements

Evaluation – Measuring Population Based Outreach

Qualitative Evaluation

NACDD Archived Webinar “Braiding and Blending Funding”

Social, Policy, Environmental Change (Domain 1)

Health Systems Change (Domain 3)

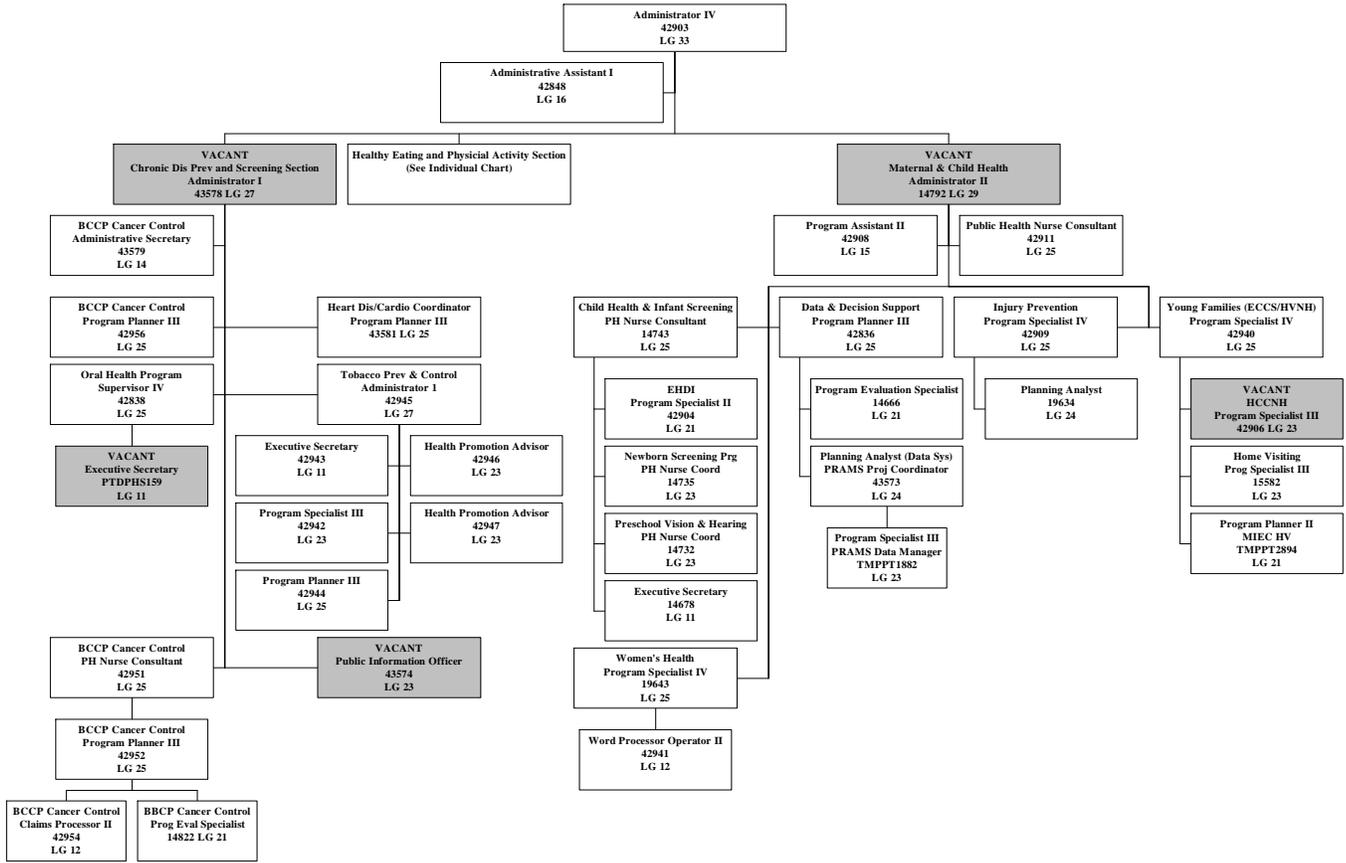
RFPs

Contracts

# Appendix V

## Organizational Chart 8/1/13

### Population Health and Community Services



### Healthy Eating and Physical Activity Section

